Conclusion: This case is an interesting demonstration of how fistulating Crohn's disease occurs regardless of the perianal tissue structure. In addition, reconstructive surgery does not guarantee a cure and patients considering such options should be alerted to this fact.

0362: AN UNUSUAL CASE OF HAEMATEMESIS

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Introduction: Haemobilia from cholecystitis is rare. It is even more uncommon for this to present with upper gastrointestinal (UGI) haemorrhage, with only four reported cases in the literature. There is one reported case of complete disintegration of the gallbladder presenting with haemoperitoneum.
We report a unique case of severe cholecystitis, which presented and was treated as UGI bleed, before progressing to massive haemoperitoneum.
Case study: A 72-year-old male presented with a three-week history of epigastric pain and three episodes of acute UGI bleed. Urgent endoscopy demonstrated apparent duodenal ulcer, which was injected with adrenaline. In the following 36 h the patient deteriorated into refractory shock, necessitating emergency laparotomy.
At operation there was an inflammatory mass surrounding the duodenum and biliary tree. Exact anatomy and the gallbladder were not identifiable. An arterial bleed within this area was addressed, stabilising the patient. Postoperative recovery was further complicated by biliary leak.
Conclusion: This case demonstrates an incredibly rare complication of cholecystitis. Blood around the ampulla of vater at endoscopy should prompt further investigation of the biliary and arterial trees. Diagnosis is more difficult in the absence of haemobilia and can easily be mistaken for duodenal ulceration.

0457: CASE STUDY: CONGENITAL SYNGNATHIA

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Introduction: Syngnathia is the congential fusion of the maxilla and mandible by bony and membranous connections.
Case study: A child with bony and membranous syngnathia is presented, born at term at Queen Elizabeth's hospital, Blantyre, Malawi. Following birth it was noted there was lack of opening between the maxilla and mandible and thus the child was unable to breastfeed from the 18-year-old primiparous mother. There was no history of previous congenital abnormality in either family. CT scanning indicated bilateral bony fusion in the molar region and membranous fusion alone more anteriorly; a pinhole-sized passage was noted on CT scan. A probe was passed into the oral cavity, eventually allowing passage of a nasogastric tube to allow feeding for the first stages of life. At two months the mucosa was separated and an osteotomy was performed posteriorly, with dressing pack placed between the molars to prevent mucosal re-fusion. Ventilation was via tracheostomy.
Conclusion: One week post-operatively, the patient was able to suckle and the tracheostomy tube was removed. Despite aggressive physiotherapy the patient required a further two osteotomies in an effort to allow weaning. Surgical management of this patient is presented.

0480: AN INTERESTING CASE OF AN ADULT WITH PERINEAL TESTIS PRESENTING WITH RECTAL SYMPTOMS

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Introduction: A 49-year-old gentleman presented to colorectal surgery clinic with rectal pain and spasms lasting 30 minutes after ejaculation. He denied any other colorectal symptoms.
Case study: Preliminary investigations & clinical examination were unremarkable. On examination under anaesthesia interestingly we found a fixed left perineal testis and empty left hemiscrotum. This clearly explained the cause of his unusual symptoms.
Perineal testis is a very rare condition with a limited number of cases reported in the literature. All of these are due to congenital maldescedance in the young children.
Conclusion: We are reporting a very interesting case of Perineal testis in a young adult with an unusal presentation, which highlights the importance of scrotal examination in patients presenting with similar symptoms.

0511: A SERIES OF UNUSUAL CHILDHOOD PRESENTATIONS OF ABDOMINAL NON-HODGKIN'S LYMPHOMA

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Introduction: Non-Hodgkin's Lymphoma [NHL] is a relatively common childhood cancer, which can present in a myriad of ways. Paediatric surgeons, as the first port of call in children with abdominal complaints, must be aware of this disease in their assessment of the child with significant unexplained disease presentations, especially prolonged or unresolving. This case series highlights some unusual presentations of paediatric NHL.
Case study: We describe three acute presentations of abdominal NHL. The first is a child with a history of intussusception presenting with an acute abdomen and initial imaging suspicious for recurrence. The second child, also presenting with an acute abdomen had what appeared to be an appendiceal abcess. While the third child presented with unilateral lower limb oedema and a small bowel mass believed to be a viral inflammatory response. All three patients were subsequently diagnosed with abdominal NHL.
Conclusion: This case series illustrates the array of presentations of abdominal NHL and the diagnostic challenges that these diseases can provide. The clinical signs and symptoms of children with NHL demonstrate tremendous variability and therefore the open-minded care of paediatric patients with abdominal symptoms is imperative so that the diagnosis of these dangerous and potentially fatal neoplasms is not delayed.

0526: A BODYBUILDER WITH AN UNUSUAL PROBLEM; MASSIVE TRANSVAGINAL SMALL BOWEL EVISCERATION

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Introduction: Transvaginal evisceration of the small bowel is an uncommon surgical emergency with fewer than one hundred cases reported; nearly two thirds follow transvaginal hysterectomy and one third follow transabdominal hysterectomy. The precipitating factor is frequently sexual intercourse.
Case Study: A 51-year-old female professional bodybuilder presented with multiple small bowel loops extruding from the vagina following intercourse. Twenty-three months previously she had a total abdominal hysterectomy for fibroids. Other previous surgeries included umbilical and upper midline hernia repairs and breast augmentations. She used a cocktail of performance-enhancing drugs including anabolic steroids and testosterone and had no menses for twenty years while weight training. The patient complained of acute severe lower abdominal pain with no significant bleeding. In the Emergency Department she became shocked and was transferred to theatre where she underwent a laparotomy, transvaginal reduction of the small bowel -which was viable, and closure of the vaginal vault. Post-operatively she made excellent progress, resuming bowel function and walking out of the hospital by thirty-six hours.
Conclusion: Risk factors included total abdominal hysterectomy and increased intra-abdominal pressure due to bodybuilding. Her rapid clinical deterioration as bowel risked strangulating validates the need for expedited surgical intervention following detection of any evisceration particularly when very large.

Posters: Collaborative Research and Audit

0035: MOVING TOWARDS 24 H DISCHARGE FOLLOWING BARIATRIC SURGERY: ROOM FOR IMPROVEMENT

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Aim: Minimized post-operative, inpatient stay improves patient satisfaction and hospital efficiency. Discharge within 24hrs of bariatric surgery has previously been shown as safe and introduced as a target at our centre. We review current practice and areas for improvement.